Indiana State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 005011 | A. BUILDING _____ B. WING _____ | 10/24/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARION GENERAL HOSPITAL | 441 N WABASH AVE MARION, IN 46952 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>This visit was for investigation of one hospital licensure complaint.<br><br>Complaint Number: IN00096883<br>Substantiated: No Deficiencies cited<br><br>Date: 10/24/11<br><br>Facility Number: 005011<br><br>Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor<br><br>Marion General Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff and 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules<br><br>QA: claughlin 11/16/11 | S 000 | | |